Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

ANKUR MEHTA DO
3100 TIMMONS LANE SUITE 250
HOUSTON TX 77027

Respondent Name
ARCH INSURANCE CO

Carrier's Austin Representative Box
Box Number 19

MFDR Tracking Number
M4-13-1124-01

MFDR Date Received
JANUARY 8, 2013

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: The requestor did not submit a position summary in the dispute packet.

Amount in Dispute: $194.61

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: The respondent did not submit a response to this request for medical fee dispute resolution.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
July 23, 2012	CPT Code 99202	$169.61	$169.61
	HCPCS Code A4566	$25.00	$0.00
TOTAL		$194.61	$169.61

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.203, effective March 1, 2008, *33 Texas Register 364*, sets the reimbursement guidelines for the disputed service.
3. The services in dispute were reduced/denied by the respondent with the following reason codes:

   Explanation of benefits
   - 97-The benefit for this service is included in the payment/allowance for another service/procedure that has

already been adjudicated
- 18-Duplicate claim/service.

Issues

1. Is the requestor entitled to additional reimbursement for CPT codes 99203?
2. Is the requestor entitled to reimbursement for HCPCS code A4566?

Findings

1. The issue in dispute is whether the requestor is due reimbursement for the disputed office visit.

   Per 28 Texas Administrative Code §134.203(c)(1)(2), "To determine the MAR for professional services, system participants shall apply the Medicare payment policies with minimal modifications.
   (1) For service categories of Evaluation & Management, General Medicine, Physical Medicine and Rehabilitation, Radiology, Pathology, Anesthesia, and Surgery when performed in an office setting, the established conversion factor to be applied is $52.83. For Surgery when performed in a facility setting, the established conversion factor to be applied is $66.32.

   (2) The conversion factors listed in paragraph (1) of this subsection shall be the conversion factors for calendar year 2008. Subsequent year's conversion factors shall be determined by applying the annual percentage adjustment of the Medicare Economic Index (MEI) to the previous year's conversion factors, and shall be effective January 1st of the new calendar year. The following hypothetical example illustrates this annual adjustment activity if the Division had been using this MEI annual percentage adjustment: The 2006 Division conversion factor of $50.83 (with the exception of surgery) would have been multiplied by the 2007 MEI annual percentage increase of 2.1 percent, resulting in the $51.90 (with the exception of surgery) Division conversion factor in 2007."

   To determine the MAR the following formula is used: (DWC Conversion Factor/Medicare Conversion Factor) X Participating Amount = Maximum Allowable Reimbursement (MAR).

   The 2012 DWC conversion factor for this service is 54.86.

   The Medicare Conversion Factor is 34.0376

   Review of Box 32 on the CMS-1500 the services were rendered in zip code 77027, which is located in Houston, Texas. Therefore, the Medicare participating amount will be based on the reimbursement for Houston, Texas.

   The Medicare participating amount for code 99203 is $105.35

   Using the above formula, the Division finds the MAR is $169.80. The requestor is seeking $169.61; this amount is recommended for reimbursement.

2. The respondent denied reimbursement for HCPCS code A4556 based upon reason code "97." On the disputed date of service the requestor billed codes 99302, 95886, 95903, 95904, 95934, and A4556. According to Medicare policy this code is a bundled code; therefore, reimbursement cannot be recommended .

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due for the specified services. As a result, the amount ordered is $169.61.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $169.61 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order

Authorized Signature

		10/10/1013
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, effective May 31, 2012, *37 Texas Register 3833*, **applicable to disputes filed on or after June 1, 2012**.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812